Your Anthem Benefits

Anthem

State of Indiana Benefits Comparison
Summary of Benefits for 2013

Please note: As we receive additional guidance and clarification on federal health care reform from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

	CONSUMER-DRIVEN HEALTH PLAN 1	CONSUMER-DRIVEN HEALTH PLAN 2	TRADITIONAL PPO
Deductible (Single/Family) **Deductibles are combined network and non-network for Consumer-Driven Health Plans ONLY**	$ 2,500 single network/non-network $ 5,000 family network/non-network	$ 1,500 single network/non-network $ 3,000 family network/non-network	**Network/Non-Network** $750 single/$1,500 single $1,500 family/$3,000 family
	When applicable, the family deductible must be satisfied by either one enrollee or all enrollees collectively before any covered services are paid by the plan. The single deductible does not apply to a family plan.		
Out-of-Pocket Maximum (Single/Family) **Out-of-pockets are combined network and non-network for Consumer-Driven Health Plans ONLY**	$4,000 single coverage $8,000 family coverage	$3,000 single coverage $6,000 family coverage	**Network/Non-Network** $2,500 single/$5,000 single $5,000 family/$10,000 family
	When applicable, the family out-of-pocket limit must be satisfied by either one enrollee or all enrollees collectively before it applies under the plan. The single out-of-pocket limit does not apply to a family plan.		
	Note: The out-of-pocket maximum limit includes all deductibles and/or coinsurance you incur in a benefit period. After you or the family collectively have met the out-of-pocket limit, the plan will begin paying 100% of covered charges for the remainder of that calendar year except for non-network human organ tissue transplant services.		

	CONSUMER-DRIVEN HEALTH PLAN 1	CONSUMER-DRIVEN HEALTH PLAN 2	TRADITIONAL PPO
Professional Office Services Including allergy – testing and treatment – serum and injections	20% Network/40% Non-network per visit	20% Network/40% Non-network per visit	30% Network/50% Non-network per visit
Preventive Care Services Services include but are not limited to: Annual physical exams, pelvic exams, pap testing, PSA tests, immunizations, annual diabetic eye exam, routine vision and hearing exams • Physician home and office visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • Routine mammograms • Screening colorectal cancer exam/laboratory testing **All preventive services are limited to one of each service per year per covered member** **If the office visit is billed separately or if the primary purpose of the office visit is not for the delivery of a preventive service, cost sharing may be imposed for the office visit**	Covered In Full Network/40% Non-network Both In-Network and Out-of Network <u>not</u> subject to deductible	Covered In Full Network/40% Non-network Both In-Network and Out-of Network <u>not</u> subject to deductible	Covered In Full Network/50% Non-network Both In-Network and Out-of Network <u>not</u> subject to deductible
Medical Supplies, Equipment & Appliances	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
Maternity Services	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
Inpatient Facility Services	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
Outpatient Facility Services	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
Professional Inpatient/Outpatient Services	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
Emergency (ER) and Urgent Care: • Emergency Care in ER • Urgent Care Facility	 20% Network/20% Non-network 20% Network/20% Non-network	 20% Network/20% Non-network 20% Network/20% Non-network	 30% Network/30% Non-network 30% Network/30% Non-network
Ambulance	20% Network/20% Non-network	20% Network/20% Non-network	30% Network/30% Non-network
Outpatient Therapy Services (Combined Network and Non-network limits apply) Limits apply to: • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits • Speech therapy: 25 visits	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network

	CONSUMER-DRIVEN HEALTH PLAN 1	CONSUMER-DRIVEN HEALTH PLAN 2	TRADITIONAL PPO
Diabetes Self Management Training	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
Diagnostic Services (i.e. lab, x-ray, MRI)	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
Temporomandibular Joint (TMJ) Services • Outpatient facility • Provider individual • TMJ surgery - professional services • Private Duty Nursing limited to $5,000 plan maximum per enrollee	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
Hospice	20% Network/20% Non-network	20% Network/20% Non-network	30% Network/30% Non-network
Home Health Care No RN/LPN unless billed through a home health care agency	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
Home IV Therapy	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
Managed Mental Health including Substance Abuse **Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained, benefits will not be allowed.**	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network
Human Organ and Tissue Transplants (HOTT) **Specialty** Network See contract for other maximums and exclusions	20% Network/40% Non-network	20% Network/40% Non-network	30% Network/50% Non-network

Prescription Drug Coverage (applies to all 3 plans) – THIS COVERAGE IS ADMINISTERED BY EXPRESS SCRIPTS[1]
Below benefits apply after medical deductible has been met; prescription expenses accumulate to the OOP maximum

	Retail Rx (Up to a 30-day supply)	Mail Order Rx (Up to a 90-day supply)
Generic	$10 co-pay	$20 co-pay
Formulary	20% - minimum $30, maximum $50	20% - minimum $60, maximum $100
Brand Non-Formulary	40% - minimum $50, maximum $70	40% - minimum $100, maximum $140
Specialty	40% - minimum $75, maximum $150 (30-day supply only)	

See Benefit Booklet for exclusions

Notes:

- [1]***Prescription benefits are being administered by Express Scripts. Any questions related to prescription coverage should be directed to (877)841-5241.***
- *Non-network human organ and tissue transplants are excluded from the out-of-pocket limits*
- *Dependent age: to the child's 26th birthday*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a non-network provider, the member is responsible for any balance due after the plan payment.*
- *Benefit period = calendar year*
- *We encourage you to contact our mental health subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.*
- *Kidney and cornea transplant services are treated the same as any other illness and subject to the medical benefits.*

Precertification:

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.